

# BULLETIN

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## THE TREATMENT OF LARGE MYOMATOUS TUMORS OF THE UTERUS. MYOMOTOMY AND HYSTEROMYOMECTOMY.

By HOWARD A. KELLY, M. D.,

*Gynecologist and Obstetrician to the Johns Hopkins Hospital, and Professor of Gynecology in the University.*

(READ AT A MEETING OF THE JOHNS HOPKINS HOSPITAL MEDICAL SOCIETY, MARCH 2, 1891.)

I have here four large myomatous uterine tumors, my most recent myomotomy and hysteromectomies. Each of the specimens is pretty nearly the size of a pregnant uterus in the

them to change their gait and find a new equipose for the body with the shoulders thrown back.

A complete mimicry of the exaggerated posture and gait of pregnancy is rarely observed in the myomatous uterus because the main masses of such tumors are usually disposed laterally in the abdominal cavity, over the normal centre of gravity of the body, as well as anteriorly, and the change in shape is much less rapid. The deliberate gait, however, is oftenest observed.

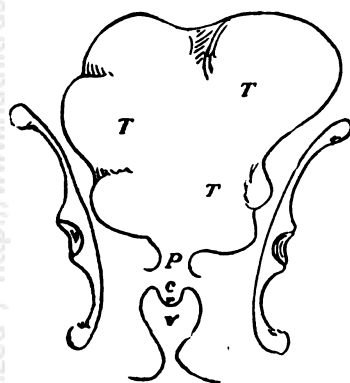


FIG. 1.

Represents a coronal section of the pelvis through the acetabula. T. T. T. is a large myomatous uterine tumor filling the lower part of the abdominal cavity, c is the cervix uteri, and v the vagina. This diagram differs generically from three of the cases under consideration in that the broad ligaments in this are not lifted up out of the pelvis.

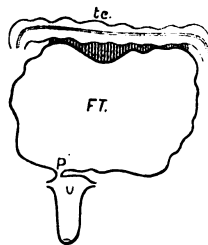


FIG. 2.

Shows the large myomatous mass FT, attached at P to the fundus of the uterus U, and above closely and widely adherent to the transverse colon tc, and behind this to the small intestines.

latter months (v. Fig. 1); when in the abdominal cavity they closely simulated the protuberant stomach of advanced pregnancy, even to the degree of necessitating some of the women harboring

### CASE I.

#### *Large Myoma Uteri.—Myomectomy.—Recovery.*

The first tumor removed was this mass—25 × 20 × 17 cm.,—taken from a negress sent me by Dr. C. Morris Cheston, of West River, Md. An abdominal incision was made 20 cm. in length, over the most prominent part of the tumor.

The tumor was found attached to the right side of the fundus uteri by a short fleshy pedicle 3 cm. long, containing a few blood vessels, from one to one and a half millimeters in diameter (v. Fig. 2).

It was at once clear that the large growing mass was not dependent upon this insufficient source for its vitality.

The query was answered by discovering at the opposite pole of the tumor a fringe of large dilated sinuous omental vessels, from 2 to 3 mm. in diameter and from 3 to 5 cm. in length, parallel to one another and disposed transversely in the abdomen, occupying the whole of the omentum, appearing to spring from the lower border of the transverse colon.

**A Case of Conservative Caesarean Section.—DR. KELLY.**

I here present to the Society my fourth Caesarean Section, the first three performed in Philadelphia, and this last in the Johns Hopkins Hospital; all of them have been successful in saving both mother and child. Two of these cases were operated upon under an absolute indication, the Caesarean operation being imperative, in one instance on account of extensive pelvic cellulitis,<sup>1</sup> the woman having been in labor two weeks, the second case being absolutely necessary on account of a large bony tumor choking the pelvis.<sup>2</sup> The other case was operated upon for a relative indication, as it would have been easy to have performed craniotomy.<sup>3</sup> The present patient, whom I here show the society, was also operated upon under a relative indication.

Mrs. D. is a patient of Dr. R. H. Smith of Havre de Grace, Maryland. She is Irish by birth, 36 years of age, weighs 115 pounds, is 132½ cm. in height. Her massive face, long body, flat pelvis and curved thighs show that she is rachitic. She was quite well as a baby, and until her eighth or ninth year, when she was paralyzed, after which it was quite a while before she could work again. In July, 1887, she had her first child at term. Craniotomy was performed and a dead foetus was delivered by Dr. Smith with extreme difficulty. On the 27th of August, 1888, she was again delivered after a frightful labor, lasting fourteen hours, when she took ether and a dead child was forcibly extracted. She was so ill after this that she was not expected to recover. She menstruated last in April, 1890. The time calculated for this present labor was January 20, 1891.

Pelvic measurements were: anterior superior spines, 23 cm., crests of the ilia, 26 cm., Baudelocque's diameter, 19 cm., conj. diag., 9 cm., conj. ver. estimated at 7.5 cm. The head was floating high up above the brim of the flattened contracted pelvis in the first position. The breech lay in the right hypochondrium. She was seen by my friend, Dr. L. E. Neale, who concurred with me in my opinion. She fell into labor January 16, 1891, a week earlier than expected. After six hours of hard labor pains, the large head still remained above the pelvic brim, just as movable as at the beginning.

Caesarean section was determined upon from the character of the previous labors, as well as the evident, marked disproportion between the fully developed child in utero and the contracted pelvis.

I am indebted to Dr. D. M. Reese, who stood by, for the following accurate steps of the operation performed January 16, 1891.

Exact time incision made in the skin, 4.17.45 p. m. Length of abdominal incision, 16 cm. Exact time of incision into uterus, 4.18 p. m. Estimated uterine incision uncontracted, 20 cm.; contracted 13 cm. No placenta previa Caesariana? Amount liquor amnii, 800 to 1000 cc. Child caught by left arm, dropped and caught by breech and extracted. Exact time of delivery of child, 4.18.45 p. m. Delivery of placenta attached posteriorly, 4.19.45 p. m. Duration of suture of uterine wound, began 4.20.45, ended 4.27.45. Number of deep uterine sutures, 7. Number of half deep sutures, 8. Exact time began to close abdominal incision, 4.30.58 p. m. Number of deep abdominal sutures, 10. Number of superficial abdominal sutures, 10. Time of complete closure, 4.39.5 p. m. Time of last deep suture tied, 4.36 p. m. Time of last superficial suture tied, 4.39.5 p. m. Complete length of time of whole operation from first incision to tying last superficial suture, 21.45 minutes. Pulse of mother at 4.21.5, during operation, 68 regular and volume good. Hypodermic of Ergot, 15 minims, given at end of operation. Quantity of anaesthetic (Chloroform), 50 cc. Began chloroform at 4.10 p. m., stopped chloroform at 4.40 p. m. Foetal pulse before operation 144, at birth 168.

The child was thus born 1 minute after the operation was begun, and I began to suture and close the uterine incision 3 minutes after the beginning of the operation.

The duration of the operation down to complete closure of the uterus, was 10 minutes.

The duration of the whole operation down to the complete closure of abdominal incision was 21½ minutes.

Every preparation had been so carefully made beforehand that not a moment's time was lost in proceeding from step to step, and the whole operation was completed with despatch, although without any undue haste.

The patient's pulse was 72 before the operation, 68 once during the operation, and 72 after, which was satisfactory evidence that there was no shock.

<sup>1</sup> *V. Med. News*, Phila., Sep. 22, 1888.

<sup>2</sup> *V. Med. and Surg. Reporter*, Phila., Jan. 25, 1890.

<sup>3</sup> *V. Amer. Jour. Obs.*, Vol. XXIII, April, 1890.

The child, a male, was born slightly cyanosed, crying as he came out of the incision. His pulse at birth was 168, 24 beats quicker than in utero. A half hour after birth the pulse was 158. He assumed the normal pink color within 5 minutes.

There was no apnoea due to the rapid delivery. The flexed child measured 24 cm. in length and extended 49 cm. from heel to vertex.

Head measurements were: occipito-mental diameter 14 cm., exactly as calculated previous to birth, circumference 35.5 cm. Occipito-frontal diameter 11.6 cm., circumference 34 cm. Sub-occipito breg. 10.5 cm., circumference 31. Biparietal diameter, 9 cm. Bitemporal diameter, 8.25 cm. The head was beautifully rounded, owing to absence of moulding. The exact weight of the child was 3175 g., equal to 7 lbs.

The mother made an excellent recovery in every way, her highest temperature being 100.4° on the second day. After this, it did not reach 100° at any time.

The sutures were removed in six days. Union was perfect throughout. She nursed the baby from the second day on. She returned home February 14, and has since written that she is in perfect health.

**Cases Treated by Koch's Method.—DR. MORISON.**

[See *Bulletin* for February, No. 11, p. 38.]

**Spurious Ankylosis of Jaws.—DR. HALSTED.**

Dr. Halsted exhibited a patient upon whom he had operated successfully for the cure of spurious ankylosis of the jaws, and said: "This little boy, at 14 years, was profoundly salivated when he was five years old. The ulceration from the mercurial inflammation was so extensive that all of the mucous membrane lining the left cheek was destroyed. Several pieces of bone were exfoliated from the upper and lower jaws on the left side. In two years the sores were completely cicatrized. During the entire process of cicatrization the boy wore a piece of rubber between his teeth. Notwithstanding this precaution the boy could not separate his incisor teeth more than one cm. when he presented himself six years ago to a Baltimore surgeon for operation. The operation was not a successful one, for, when admitted to this hospital, October 13, 1890, the incisor teeth could not be separated more than about 0.5 cm. We have performed three operations upon the boy and now he is permanently cured.

Operation I. October 16, 1890. An incision, from the left angle of the mouth to the anterior border of the masseter muscle, was made through the skin of the cheek and through the dense connective tissue which bound the jaws together from about where the canine teeth might have been back to the anterior border of the ramus of the lower jaw. We were then confronted with two raw triangular surfaces which we had made. These surfaces, one above and one below, were, of course, parallel to each other until the jaws were forced apart. The jaws having been forced apart, the planes of these surfaces had an inclination of about 45°—the bases of the triangles meeting at the fornix of the jaws, and the apices, corresponding to the angle of the mouth, being widely separated. A large piece of mucous membrane taken fresh from the cheek of a dog was transplanted to the raw triangular surfaces and held in place by stitches.

October 27th. For seven or eight days it seemed as if a portion, at least, of the transplanted mucous membrane had become attached, but to-day it is certain that the entire graft is dead. It is accordingly removed.

Operation II. November 4, 1890. The granulations covering the triangular surfaces were shaved off with a scalpel and the fresh raw surfaces were covered according to Thiersch's method with three or four grafts of skin. The grafts were held in place by fine needles used as tacks. The gutta-percha tissue and the gauze pads were also held in place by the needles. November 8th. The dressing is removed. The grafts have taken perfectly.

December 1st. The boy can separate his incisor teeth about 3.5 cm.

The ankylosis mandibulae is permanently cured; for the raw surfaces have been so completely covered with skin that no adhesions and no contractions can take place.

Operation III. December 2nd, 1890. To close the cleft of the cheek, a horizontal incision was made through the skin of the left cheek a little below the inferior margin of the left orbit. From the extremities of the horizontal incision two vertical incisions were made. The anterior vertical incision extended to the angle of the mouth; the posterior to the outer extremity of the cleft in the cheek. The flap of skin so defined was reflected down to

close the defect in the cheek. The skin surface of the flap was turned towards the mouth, and the raw outer surface of the flap was covered with skin, transplanted according to Thiersch's method.

The boy can now, as you see, open his mouth quite naturally. I am sure that he is permanently cured. I think that the case is one well worth presenting to the society; for such cases are rarely much benefited by operation, and this case has been cured by a new and not very difficult method.

#### A New Needle-Holder.—Dr. WILLIAMS.

Dr. Williams exhibited a needle-holder which he had devised and said: Some of the various forms of needle-holders devised for Hagedorn needles fulfil all the requirements of a perfectly antiseptic instrument and leave nothing to be desired in that respect. But they are only adapted to the use of Hagedorn needles and cannot be used with the ordinary curved surgical needles, which are still used by many. Holders for this class of needles offer a large field for improvement; for I know of but few needle-holders, with any sort of spring catch, which are not made with several screws or perma-

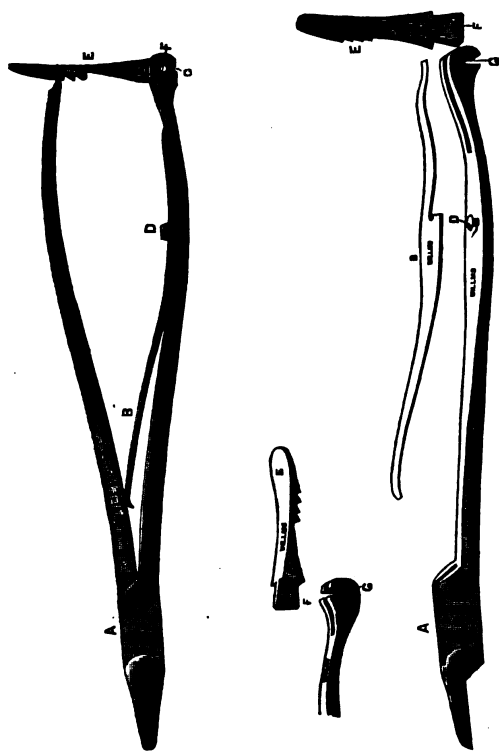


FIG. 1.

FIG. 3.

FIG. 2.

nent joints, which cannot be removed and cleansed, thereby placing the instrument in the category of uncleanly instruments.

The following needle-holder is a modification of one devised by Professor Zweifel, of Leipzig, and differs from it only in the fact that all its parts are readily separable, instead of being permanently united as in his instrument.

The instrument presents the general form of most holders for flat needles and is provided with a spring catch at the end of a handle, and is represented in Fig. 1.

The blades are provided with a shouldered French lock and are readily taken apart (A); the jaws are lined with copper to prevent slipping of the needle. The main improvement presented by this instrument is the spring (B) and catch (E) which can be readily removed for cleansing and whose form is readily seen in the drawings.

Instead of by a rivet, the catch is attached to the lower blade as follows: The axle is firmly placed at the lower part of the catch as shown at (F); and instead of a mere rivet hole at the end of the lower blade, we have the slot (G) into which the axle is placed as shown in Fig. 3. The catch is then turned up into its normal position and is held in place by the end of the

spring (B). The spring is provided with a fenestrum, which slides under the knob (D), by which it is held in place. It is placed in position by placing its small end under the end of the catch (Fig. 1) and then pushing the fenestrum firmly under the knob (D). The upper blade is then placed in position and the instrument is ready for use.

The instrument has proved itself of practical value and offers no difficulty in taking apart and cleansing.

I do not pretend to claim any great amount of originality for the instrument, for it is merely a combination of several forms; but I do claim that it is perfectly cleanly and fairly simple in its construction.

The instrument was made by Mr. Chas. Willms, to whom I wish to express my thanks for the able manner in which he carried out my instructions.

Drawings five-ninths size of instrument.

Dr. Halsted asked Dr. Williams if needles curved on the flat were ever to be preferred to needles curved on the edge—to Hagedorn's needles. Dr. Williams replied that he preferred the ordinary needles merely because he had always used them.

Dr. HALSTED:—"Of the very many surgeons who use the so-called Hagedorn's needles, there are probably not a few who do not understand the peculiar advantages of them. I am quite sure of this because of the popularity of a certain holder which defeats the very object of the needle which it is designed to hold.

The ordinary strongly curved needles—needles curved on the flat—must be grasped by the needle-holder in such a way that one jaw of the holder presses the concave side of the needle at two points and the other jaw presses the convex side of the needle at an intermediate point. If it be necessary to exercise much pressure the needle grasped in this way may readily be broken.

Inasmuch as strongly curved needles are used as a rule only for the application of more or less difficult stitches—of stitches in the deeper recesses of wounds—the breaking of such a needle just before the completion of a stitch may be very annoying.

Hagedorn's needles are curved on the edge and flattened on the sides. They cannot, except with great force, be broken by a holder which grasps them properly—which grasps their straight, flat sides.

New holders for Hagedorn's needles are devised almost every year. One of the holders, the most popular one perhaps in this country, was devised about six years ago by a New York practitioner. It grasps the needles by their curved edges and thus exposes the needles to the very danger which they were devised to prevent.

Twenty years or more before Dr. Hagedorn described his needles it had occurred to Dr. Joseph Schnetter, attending surgeon to the German Hospital, New York, to devise not only needles precisely like the so-called Hagedorn needles but also a needle-holder essentially the same as that which Dr. Hagedorn regards as his improved needle holder.

A few years ago I saw Dr. Schnetter's original needle-holder among the instruments of the German Hospital, and was informed that it had seldom been used by any one except the inventor."

#### Case of Amoeba Coli.—Dr. LAFLEUR.

[To appear in the next number.]

#### Meeting of February 16th, 1891.

Dr. OSLER in the chair. 39 members present.

#### Exhibition of Cases.—Dr. HALSTED.

Dr. Halsted exhibited ten cases of hernia where a radical operation had been performed in accordance with the method described in the *Bulletin*, No. 1, Vol. I.

#### Tuberculosis of Knee.—Dr. FLEXNER.

J. W., colored, aet. 20, came into the Hospital on November 11, 1890, suffering from a large, swollen right knee-joint. He gave briefly the following history: The knee began to pain him two years ago, following a fall. There is no phthisical history. The pain in the knee is inconstant, and the swelling came on gradually.

On November 14, 1890, the knee-joint was opened and a quantity of caseous